".. I think this is maybe our Achilles Heel...." Exploring GPs' responses to young people presenting with emotional distress in general practice. A qualitative study.

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Article summary

Article Focus:

1. an exploratory study
2. to examine GPs' views and experiences of consulting with young people experiencing emotional distress
3. to understand GPs perspectives

Key Messages

1. GPs collectively describe anxiety and uncertainty about their clinical practice when consulting with young people in distress, independently of age and gender
2. Anxiety relates to professional performance; interacting with young people and the complex nature of presentations of emotional distress in primary care
3. Unless anxiety and uncertainty are addressed GPs will continue to miss opportunities to address early emotional difficulties and young people's mental health needs in primary care will continue to be poorly met

Strengths and Limitations

1. Qualitative research in under -examined areas offers new insights and explores why behaviours might arise
2. The data contributes to theory building and offers theoretical generalizability
3. Theoretical sampling led to only white British born GPs participating so other cultural perspectives were not included

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Main text

Introduction

Emotional distress in young people is common. It may indicate an associated mental heath problem, with at least 10% of 10-15 year olds affected [1] and 17 % of 16-19 year olds [2] (based on household surveys). Proxy markers of distress, such as reported incidences of self-harm derived from community based studies, show 10% of adolescents report having self-harmed. [3]

Data from populations of young people who consult their GP reveal higher rates of psychological distress, of the order of 20-30%. [4 5] GPs identify serious mental illness but often fail to detect less severe manifestations [6] and appear reluctant to discuss emotional issues[7]; unless offered cues by the young person in the consultation [8] or if other factors are present such as a previous history of a suicide attempt or a pattern of frequent consulting [9]. Young people's presentations in primary care are often complex and present with behavioural, psychosocial, academic and familial problems which can be problematic to untangle. They may suggest underlying co-morbid mental health problems. It has been reported that often the 'most important features in terms of assessment may be concealed or hidden'.[10].

A key concern is the difficulty of distinguishing between 'moodiness' or a persisting emotional disorder and GPs have expressed a worry at 'over-medicalising young people's lives'.[11] Illiffe & colleagues found that GPs were uncomfortable about making a diagnosis of depression in young people (the most common, but often coexisting, mental health problem in adolescence).

This sits in contrast to GPs' increasing involvement of common mental health problems in older patients [12 13]and also to a broadening of the frames of reference by which emotional distress in adults is regarded. Although a biomedical perspective dominates, supported by an array of NICE clinical guidelines, Dowrick [14]and Reeve [15] have offered alternative frameworks and refer to the insights derived from the

wisdom traditions. Historically, GPs have been found to be dismissive of their role in addressing social issues in adult mental ill-health [16] although this position is shifting with greater awareness of the lay perspective, which typically favours the causes of mental ill-health (notably depression) as being social in origin [17].

Despite the challenge of responding to emotional distress in adolescence and the patchy, often inadequate provision of secondary care services [18 19]a series of policy directives have emphasised the role of GPs and other front-line services, in the promotion of psychological well-being and the early indication of difficulties. [20 21 22] Practitioners are expected to have 'sufficient knowledge, training and support 'in this area including competence in 'active listening' and conversational technique' [23].

There is a growing body of evidence examining young people's experiences of talking to GPs about emotional problems. They reveal a mixed picture including a reluctance to disclose [24], a fear of being judged or offered medication [25]. Much less is known about GP perspectives. This paper presents a qualitative, exploratory study which examines GPs' views and experiences of consulting with young people presenting with emotional distress.

Method

Study Design

The study took place in the North East of England in 18 general practices based in urban, rural and semi-rural communities serving predominantly socio-economically disadvantaged patients. The qualitative study comprised of in depth individual interviews with GPs recruited using theoretical sampling. As early theoretical ideas emerged successive GPs were recruited on the basis of their capacity to contribute to the development or abandonment of initial theoretical constructs.

Data were collected between January 2010 to May 2011

Participants

GPs with less than four years clinical experience were excluded. The initial recruits were selected on the basis of their relevant experience and their ability to generate early data which would scope the terrain of the area under enquiry.

GPs were approached by telephone and email contact and sent information sheets. A follow-up contact established their verbal consent to meet at a location of their choice.

Data collection and analysis

The audio-taped semi-structured interviews were transcribed verbatim with consent. An initial topic guide was used with the first tranche of participants based on the extant literature and developed through discussion. The topic guide was then revised on the basis of ideas arising from the early interviews, and the iterative analysis which began as soon as the first interview was undertaken. The interview guides explored doctors' experiences of consulting with young people in general and those presenting with psychological or mental health problems, GPs' understanding of depression and anxiety in adolescence, of how emotional distress presents in the surgery and the role of the GP in promoting emotional well-being in young people (See appendix 1). The guide was refined to include questions about how structural changes impacted on, and consultation style shaped, practice.

The interviews lasted between 50 to 75 minutes. Field notes and theoretical memos were kept throughout the period of data collection and analysis.

The transcripts were coded and analysed using the grounded theory method described by Strauss and Glaser [26] and revised by Charmaz .[27] The constant comparative method of analysis is core to the process and informs the theoretical sampling of recruits. Situational maps, both 'messy' and 'ordered', were constructed during this phase of analysis.[28]

The data presented here was produced after the first level of analysis was completed during which the open codes were developed by JR and subject to further examination by AC (primary care academic) and JF(sociologist)

Results

Nineteen GPs participated, 10 women. (Table1). The early iterative analysis of the data found a dominant narrative of anxiety and uncertainty about practice under-pinning the majority of the research interviews. This pervasive and disabling

emotional response to encounters with emotionally distressed young people appeared to coalesce around three domains.

These can be viewed as anxiety and uncertainty experienced by GPs in response to:

1) professional performance; in the consultation, at an external level, across disciplinary boundaries;

2) interacting with young people; and

3) the complexity of presentations of adolescent emotional distress

Anxiety related to professional performance: *In the consultation*

A prevailing finding was the sense of professional impotence which was associated with seeing or suspecting emotional distress in this age group. It was acknowledged that feeling unsure of practice led to a sense of disempowerment through not knowing what to do; in contrast to working with older patients where the options appear more clearly defined. The data collected suggested that not being able to formulate the initial presentation by a young person into a definable 'disorder' created a sense of operating in uncharted territory.

This was amplified by the lack of exposure to adolescent mental health in undergraduate medical education which was unanimously shared by all participants. Where the topic had been included in the curriculum, it was often restricted to severe mental disorder such as adolescents hospitalized with anorexia nervosa.

Anxiety related to professional performance: *at an external level*

The lack of benchmarks meant assessing one's performance in relation to peers was problematic since no 'gold standard' existed. The only NICE guideline which was referenced (concerning the management of depression in under 18 year olds) was regarded as having hampered GPs from becoming involved in the management of adolescent depression and supporting a view that there was little to be offered in primary care.

Varying arrangements within practices governing access to appointments and the ease, or not, of maintaining continuity of care were seen to contribute to professional

anxiety by impeding attentive 'watchful waiting' and some GPs described attempts to circumvent inflexible appointment systems in order to be more available to patients.

A lack of professional supervision was identified by a small number of more experienced GPs involved with Postgraduate Training and provision of mental health services at a regional level, and contrasted to systems for other professionals working with emotionally distressed patients. Leaving GPs to rely on their own personal resources, on informal collegiate support or ad hoc relationships with colleagues in secondary care resulted in a fragile structure which could amplify rather than ameliorate anxiety.

Anxiety related to professional performance: *across disciplinary boundaries*

GPs across the board expressed frustration with access to secondary care services, reporting long delays and frequent rejection of referrals, and a lack of clarity about how the services were structured and governed. GP experiences and degrees of frustration varied with an emerging picture of problematic access to services being associated with higher levels of professional anxiety. More constructive cross-disciplinary relationships were described with CAMHS workers offering clinical updates meetings and were consultants were accessible by telephone.

Anxiety related to interacting with young people

The early finding of anxiety and uncertainty in this area was under-pinned by the difficulties GPs talked about experiencing when communicating with young people. Neither the age nor the gender of the GP appeared to facilitate communication. Female patients were generally considered to be easier to talk with whilst young men were seen to be more challenging because of their perceived reluctance to seek help and their tendency to present late.

Communication difficulties included establishing a rapport, finding the right words and tone to use and dealing with silence. An inability to read the non-verbal signs, and to translate an often terse description from the young person into a coherent picture of their internal emotional state, left many GPs either relying on the accompanying parent or closing down the consultation.

Young people were seen as a highly heterogeneous group who showed variability from one presentation to the next, and also across lines of age and gender. Knowing what was 'normal' for an individual, particularly if it was presented as a principal reason for consulting with the GP, was perceived as problematic and anxiety provoking, both for the young person and for the GP.

Anxiety associated with the complexity of presentations of adolescent emotional distress

GPs' accounts of their experiences described a terrain beset with pitfalls, associated with the unspoken or with complex narratives embedded in social contexts. There was a sense of unpredictability and volatility to presentations which left GPs uncertain about how much input to offer at the initial consultation. This was in contrast to the rare but grave consequences which might arise when a young person seriously attempted or completed suicide; to which many GPs referred.

Although it was accepted that uncertainty as a feature of general practice was not restricted to the clinical area of youth mental health, the early analysis showed a distinct narrative emerging in which adolescent mental health was seen as more notably anxiety provoking because of its more nebulous presentation and multiple confounding factors, largely pertaining to the social environment. The account given in the consulting room was described as the 'iceberg' indicating that often much is left hidden, or unsaid, but which nevertheless has to be raised at some point if the young person's distress is to be addressed.

Not only is there a dominant narrative of anxiety and uncertainty surrounding how GPs make sense of adolescent emotional distress, but similar responses surround management options. Few GPs expressed any degree of confidence about how they would tackle individual presentations. A small number of those with additional roles in mental health or working with patients with substance abuse problems spoke of a more systematic approach but even established GPs with personal experience of working in 'a teen drop-in clinic' or with drug dependent patients were uncertain of their practice. A paucity of treatment options was a core finding along with a lack of clarity about what GPs might reasonably do, if supported by adequate professional development.

Discussion

Summary

Anxiety and uncertainty associated with adolescent emotional distress emerged from all GP participant accounts and from the early iterative analysis of the data. Anxiety was associated with the clinical consultation, with what was expected of the GP, and how they might best respond in the absence of few clinical guidelines and limited options to involve other health and social care professionals. Unease when communicating with young people and of interpreting their accounts of distress inhibited GPs and was compounded by the complexity of presentations which ranged from familial discord to school refusal to offending behaviour. The heterogeneity of adolescent behaviour taxed GPs as did the unpredictability of the unfolding clinical presentation which could settle spontaneously or develop into a serious mental health disorder.

Whilst there was a spectrum of levels of anxiety experienced by GPs, there was a prevailing universality about the experience. How GPs responded and managed the perceived threat to professional competence and confidence was interrogated in the next stage of the analysis.

Strengths and limitations

The management of adolescent mental health problems remains an under-investigated area of clinical practice. Previous studies have often been conducted by psychiatrists and whilst plurality of perspectives is important, unless more is known and understood about how GPs perceive the area many assumptions will go unchallenged. Using grounded theory, augmented by situational analysis, permits a rich exploration of the territory and facilities theory building.

Theoretical sampling supports theory development whilst not purporting to provide universal generalizability. After 19 in-depth interviews, buttressed by situational analysis, no new themes emerged and theoretical saturation was reached. All of the respondents were white British and whilst they were recruited on the basis of their contribution to the study, it must be acknowledged that the absence of including the

experiences of GPs raised and educated in different cultural contexts will lead to the silencing of other cultural perspectives.

The lead researcher and interviewer is a GP (JR). Interviewing peers has been described [29]as enriching the data collection because of the shared knowledge and familiarity with the clinical territory but it can lead to collusion between interviewer and respondent which needs attention and reflexivity. Co-contributors AC and JF have academic expertise in social policy and sociology which strengthened the analysis.

Comparison with existing literature

Heath asserts that *a commitment to uncertainty is fundamental to general practice:* [30]*:* 651) and Schon has described this operative landscape as a 'swampy lowland' proposing a model which advocates reflective practice as the key to dealing with uncertainty.[31] A quest for certainty in areas of complex practice, especially when it concerns individual experiences can be counter- productive and scholars have cautioned against clinging to the 'shelter of diagnosis' [32] when what is required involves attention to alleviating suffering and working purposefully with patients to catalyse their own creative capacity.[15] Illife et al's earlier cited work demonstrated that when GPs were fixed on the concept of depression as disease they were uncomfortable talking to young people. [33] [34]

This study suggests that it is the anxiety and threat to professional competence, experienced at multiple levels, and amplified with regard to the complexity of adolescent presentations and perceived paucity of management options which compromises GPs' professional engagement and inhibits them from taking a more active role.

Implications for practice and research

Inadequate preparation, both at under and post-graduate level, is pivotal in sustaining the anxiety around clinical practice. Doctors need to be introduced to the developmental trajectory of adolescence and the conceptual framework which

locates adolescence as the foundation of future health [35] both in undergraduate education and revisited in continuing professional development .

In addition, the links between general practice and CAMHS need to be strengthened both in terms of education and understanding more of how each discipline operates, but also at a pragmatic, operational level. If cross-disciplinary practice was facilitated more treatment options would be presented at a primary care or early intervention level . Evidence of effective, feasible, primary care based brief behavioural interventions would equip GPs to engage with young people with greater confidence.

The needs of young people are ill- served by the current provision [18] [19] and whilst rhetoric has called for GPs to be more involved, unless we address the disabling anxiety and uncertainty in this area practice will remain static with GPs reluctant to become involved in youth mental health.

How this fits in

GPs are known to have difficulty recognizing and responding to adolescent emotional distress. Reluctance to medicalize distress has been reported.

This study shows that anxiety and uncertainty about practice in this complex clinical area are universal and independent of age, gender, level of experience of GP.

If GPs are to play a more active role in the early identification and intervention of distress we need to know more about the factors which ameliorate or exacerbate professional anxiety about practice. Critically, adolescent mental health needs to feature in undergraduate and postgraduate curricula.

Table 1

Participant Number	Gender	Age	Salaried or Partner	Practice descriptor	Additional professional experience
01	F	50-59	S	Semi-rural Deprived	GP Postgraduate education
02	Male	50-59	S	Urban Deprived	Addiction medicine in primary care
03	Female	50-59	P	Urban Deprived; wealthy student population	Former Assoc. Specialist in CAMHS
04	Female	40-49	S	Semi-rural Deprived	Mental health Lead for a PCT
05	Female	20-29	S	Urban Deprived	
06	Male	40-49	P	Semi-rural Largely affluent	
07	Male	40-49	P	Semi-rural Mixed :	Child Protection Lead for a PCT
8	Female	30-39	S	Semi-rural Mixed :	
9	Male	50-59	P	Semi-rural Mixed :	GP lead for 'teen drop-in' clinic
10	Male	40-49	P	Urban Deprived	Mental Health and Child Protection Lead for a PCT. Substance misuse

11	Female	20-29	S	Urban Deprived	
12	Male	30-39	S	Semi-rural Mixed: largely affluent	
13	Female	30-39	S	Urban Deprived	
14	Male	40-49	P	Urban Deprived	
15	Male	40-49	P	Semi-rural Mixed :	
16	Female	20-29	S	Urban Deprived	
17	Male	30-39	S	Urban Deprived	
18	Female	40-49	P	Semi-rural Affluent	
19	Female	50-59	P	Semi-rural Mixed :	Child health lead

Anxiety paper Boxes i

Box 1. Anxiety related to professional performance: In the consultation

I've always thought young people are challenging and still do and I have more questions than answers' (06;M; 40-49;P)

so not knowing what to do is a bit of a theme really (07;M; 40-49;P)

I find the adults will accept me at face value, generally. And they come with something usually fairly clear and they want that sorting out, it might not be straight forward, it might not even be simple they might have even brought things off the internet but it is a fairly clear baggage package... what I find with younger people with psychological or emotional disorders is it's not a clearly packed problem, it's in the extreme realms of the undefined. (06;M;40-49;P)

I know we don't meet all the people we refer to but we usually have something to hang it on because of our experience as junior doctors working in hospital but with CAMHS there is nothing. (08; F;30-39;S)

Box 2 Anxiety related to professional performance: at a structural level

NICE guidelines a few years ago looked at depression in young people and kind of hampered our ability to do anything with them really (07;M; 40-49;P)

'...because it doesn't fit within any ticky box guidelines until time has passed I rarely know whether I've done the right thing, it's all in retrospect. (06;M;40- 49;P)

I'll bring people back in 1 week, I don't think this annoys my partners but it can become a bugbear....I'll squeeze them in when there are no appointments, which is probably making a rod for my own back and I wouldn't encourage trainees to do it, but I like the idea of seeing something through to its natural conclusion...its perhaps my own insecurity (14;M; 40-49,P)

What we don't have, in general practice is supervision...no counsellors are allowed to work without it but GPs are just sent out there, andI really do feel there is a huge need for it even if it is just one phone call-it's that ability to share the responsibility, not to dump it, but to genuinely share it.(04;F; 40-49;S)

Anxiety Boxes ii

Box 3. Anxiety related to professional performance: across disciplinary boundaries

Some (mental health) creatures are on the verge of being mythical beasts, ...like psychotherapists,....educational psychologists (09,M;50-59;P)

CAMHs..it feels like it's a bit of a hotchpotch really, a patched together sort of service and I'm not sure who is control....people who counsel children-I don't know much about them, how much responsibility they take.. (07;M; 4049;M)

Box 4. Anxiety related to interacting with young people

Generally consulting with young people, I often find, if I'm being honest, probably more difficult than I would expect to find it. I think I probably have this unrealistic view of myself as really sort of approachable and you know still being quite young myself compared to other GPs, being able to communicate fairly easily and fairly well with young people, then always very quickly, it becomes apparent that actually no, you are a million miles away from where they are, and they don't really relate to you very well at all....(08; F; 30-39; S)

Males with mental health issues worry me intensely, it really does seem that there is not an awful lot of trivia goes on there. By the time a male is presenting, because they don't have the tools to come to the GP very often, they don't understand that you can just come along when things are in their development, they usually come when something is really big ,black and bleak.(14;M;40-49;P)

I struggle a bit to work out how to word sort of mental health questions with to the sort of under 16 year olds particularly.... I suppose with adults I have my kind of, standard questions ..but using those sort of questions with young people often draws a blank face, and, so it's something I have to rephrase; I feel that I don't necessarily know their kind of lingo if you like...(17;M; 30-39;S)

So he went off to do a urine sample and I was pleased to speak to his parents without him, seemed easier to talk about some of the mental issues without him there... (017;M; 30-39;S)

With children and teenagers it tends to be you controlling the pace of the consultation.... and you finish the consultation when you want to (07;M; 40-49;P)

Anxiety Box iii

Box 4. Anxiety related to interacting with young people

there's no such thing as a typical teenage presentation (13;F; 30-29;S)

...and her mum said, as mum's do, oh she has dreadful mood swings on her periods, it's like living with a monster ..and then they say 'but that's normal isn't it, she is 14?'... so it's hard to know what to do (11;F; 20-29;F)

Box 5. Anxiety associated with the complexity of presentations of adolescent emotional distress

... you feel that there are these big 'no go areas' in teenage consultations which loom over you like a black cloud (11;F; 20-29; S)

They are missing school, in trouble with the police, youth offending team or not uncommonly the parent just comes by themselves...I never get a 14 year old acting out saying 'you know, I'm in trouble with my mam and dad' (10;M;40-49;P)

they are in absolute crisis one minute and then you see them a week later and they can hardly remember what it was all about (07;M; 40-49;P)

Its always a worry isn't it that you just completely get it wrong..I mean I'm conscious of this. I had someone in on Monday, parents, whose son had just hung himself at 21. I'd never seen him, he was a patient here. They had no idea anything was wrong. Nobody did....there is always that underlying things isn't there, that you might miss something catastrophic.. (01;F;50-59;S)

Anxiety Box iii

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*Uncertainty is very key to this group when you're looking - in terms of depression and suicide risk and things like that, you know, it's standard. Young people particularly young males are quite at risk of just going off and doing something. (*04; F; 40-49;S*)*

The main anxiety is what to do. (07;M; 40-49;P)

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Data sharing: Extra data is available by emailing Jane Roberts on jane.roberts@sunderland.ac.uk

This includes theoretical memos, field notes, anonymized transcripts and situational analysis diagrams.

Contributorship statement: JR was the lead investigator , conducted all of the interviews, carried out the primary analysis of the data and wrote the manuscript
AC and JF contributed to the design of the study and met regularly with JR to look at the data and the analysis at each stage to agree on the open, axial and selective codes
AC was involved with GP recruitment and commented on each draft of the manuscript including the final submission
JF read all drafts of the manuscripts and agreed with AC's final comments

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Appendix 1 Early Topic Guide

1. I'd like to talk about your experiences of consulting with young people in general

- How do you find this age group?
- Is it very different to consulting with older patients?
- What sort of problems do you see? Do they consult often?

2. Can we talk more about consulting with young people who may have psychological/mental health problems

- How do you find this clinical area?
- What about seeing YP alone/ with 'another'
- Any areas particularly tricky to broach ?

3. How do you consider possible 'mental health problems' which presenting in young people ?

- Do any examples come to mind ?
- What approach did you take
- What worked well? What was difficult?
- Is it different with other age groups

4. What are your thoughts on 'depression' and 'anxiety in young people ?

- Do you see much of it?
- Does this differ from other age groups?
- What options are there in primary care?

5. Do you think GPs have a role/or not in promoting emotional well-being in young people? Explore

Research checklist

As this is a qualitative study it does not fall within the parameters of the recommended research checklists.

A statement to this effect is included in the covering letter.

BMJ open

".. I think this is maybe our Achilles Heel...." Exploring GPs' responses to young people presenting with emotional distress in general practice. A qualitative study.

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"‥ I think this is maybe our Achilles Heel...." Exploring GPs' responses to young people presenting with emotional distress in general practice. A qualitative study.

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Article summary

Article Focus:

1. an exploratory study
2. to examine GPs' views and experiences of consulting with young people experiencing emotional distress
3. to better understand GPs perspectives

Key Messages

1. Anxiety about practice experienced when consulting with young people is the dominant finding in a first stage analysis of a qualitative study. This is independent of age and gender of GP
2. Anxiety relates to professional performance; interacting with young people and the complex nature of presentations of emotional distress in primary care
3. Unless anxiety and related uncertainties about practice are addressed GPs will continue to miss opportunities to address early emotional difficulties and young people's mental health needs in primary care will continue to be poorly met

Strengths and Limitations

1. Qualitative research in under -examined areas offers new insights and explores why behaviours might arise
2. The data presented contributes to theory building
3. Theoretical sampling led to only white British born GPs participating so other cultural perspectives were not included

"‥ I think this is maybe our Achilles Heel...." Exploring GPs' responses to young people presenting with emotional distress in general practice. A qualitative study.

Main text

Introduction

Emotional distress in young people is common. It may be the affective response to the challenges of everyday life or may indicate a mental health disorder compatible with a psychiatric diagnosis. The most recent and widely cited household survey reports at least 10% of 10-15 year olds [1] and 17 % of 16-19 year olds [2] to) to have symptoms consistent with a mental health disorder as defined by the ICD-10. Behavioural manifestations of emotional distress might include self-harm which, at a conservative estimate, appears to affect around 10% of adolescents, as reported in six studies cited by Hawton et al in a recently published review . [3]

Data from populations of young people who consult their GP reveal higher rates of psychological distress, of the order of 20-30%. [4 5] GPs identify serious mental illness but often fail to detect less severe manifestations [6] and appear reluctant to discuss emotional issues[7]; unless offered cues by the young person in the consultation [8] or if other factors are present such as a previous history of a suicide attempt or a pattern of frequent consulting [9]. Young people's presentations in primary care are often complex and present with behavioural, psychosocial, academic and familial problems which can be problematic to untangle in contrast to adult mental health manifestations which, although variable, may be less intense in their presentation . Adolescent emotional distress may indicate underlying co-morbid mental health problems and it It has been suggested that often the 'most important features in terms of assessment may be concealed or hidden'.[10]. A key concern is the difficulty of distinguishing between 'moodiness' or a persisting emotional disorder and GPs have expressed a worry at 'over-medicalising young people's lives'.[11] Illiffe & colleagues found that GPs were uncomfortable about making a diagnosis of

depression in young people (the most common, but often coexisting, mental health problem in adolescence).

On the other hand GPs' are increasingly involved in managing common mental health problems in older patients [12] Although a biomedical perspective dominates, supported by an array of NICE clinical guidelines, alternative frameworks for considering adult mental health problems have been offered . Dowrick [13]and Reeve [14] refer to the insights derived from the wisdom traditions in informing their work which moves away from a positivist understanding of emotional distress to an approach which incorporates ideas of personal agency and encourages hope. [15] Historically, research has found GPs to be largely dismissive of their role in addressing social issues in adult mental ill-health [16] . Contemporary studies reveal a shift with greater awareness of the lay perspective, which typically favours a social model adult mental ill-health [17], and a matched response by GPs mirroring popular social constructions of distress .

Despite the challenge of responding to emotional distress in adolescence and the patchy, often inadequate provision of secondary care services [18 19]a series of policy directives have emphasised the role of GPs and other front-line services, in the promotion of psychological well-being and the early indication of difficulties. [20 21 22] Practitioners are expected to have 'sufficient knowledge, training and support 'in this area including competence in 'active listening' and conversational technique' [23].

There is a growing body of evidence examining young people's experiences of talking to GPs about emotional problems. They reveal a mixed picture including a reluctance to disclose [24], a fear of being judged or offered medication [25]. Much less is known about GP perspectives. This paper presents a qualitative, exploratory study which examines GPs' views and experiences of consulting with young people presenting with emotional distress.

Method

Study Design

The study took place in the North East of England in 18 general practices based in urban, rural and semi-rural communities serving predominantly socio-economically

disadvantaged patients. The qualitative study comprised of in depth individual interviews with GPs recruited using theoretical sampling. As early theoretical ideas emerged successive GPs were recruited on the basis of their capacity to contribute to the development or abandonment of initial theoretical constructs.

Data were collected between January 2010 to May 2011

Participants

GPs with less than four years clinical experience were excluded. The initial recruits were selected on the basis of their relevant experience and their ability to generate early data which would scope the terrain of the area under enquiry; for example having a role as mental health lead or previous experience working in Child & Adolescent Mental Health services (CAMHS)

GPs were approached by telephone and email contact and sent information sheets. A follow-up contact established their verbal consent to meet at a location of their choice. Two GPs approached declined to participate. One cited forthcoming extended annual leave and another a view that as the senior partner he saw relatively few younger aged patients and suggested recruitment of a younger GP in the same practice.

Ethical approval by the Local Research Ethics Committee, the seven Primary Care Trust organizations of the region and the University of Sunderland was granted before data collection began.

Data collection and analysis

The audio-taped semi-structured interviews were transcribed verbatim with consent. An initial topic guide was used with the first tranche of participants based on the extant literature and developed through discussion. The topic guide was then revised on the basis of ideas arising from the early interviews, and the iterative analysis which began as soon as the first interview was undertaken. The interview guides explored doctors' experiences of consulting with young people in general and those presenting with psychological or mental health problems, GPs' understanding of depression and anxiety in adolescence, of how emotional distress presents in the

surgery and the role of the GP in promoting emotional well-being in young people (See appendix 1). The guide was refined to include questions about how structural changes impacted on, and consultation style shaped, practice.

The interviews lasted between 50 to 75 minutes. Field notes and theoretical memos were kept throughout the period of data collection and analysis.

The transcripts were coded and analysed using the grounded theory method described by Strauss and Glaser [26] and revised by Charmaz .[27] The constant comparative method of analysis is core to the process and informs the theoretical sampling of recruits. Early ideas were tested with subsequent participants and found to be either substantiated or rejected through the iterative process of constant comparison supported by theoretical sampling .Situational maps, both 'messy' and 'ordered', were constructed during this phase of analysis.[28]

The data presented here were generated after the first level of analysis was completed, during which only the open codes were iteratively developed by JR and subjected to further examination by AC (primary care academic) and JF(sociologist). Further analysis of the axial and selective codes will be presented in two subsequent companion papers.

Results

Nineteen GPs participated, 10 women. (Table1). The early iterative analysis of the data found the open codes to support a dominant narrative of anxiety under-pinning the majority of the research interviews. This pervasive and disabling emotional response to encounters with emotionally distressed young people appeared to coalesce around three domains.

These can be viewed as anxiety experienced by GPs in response to:

1) professional performance; in the consultation, at an external level, across disciplinary boundaries;

2) interacting with young people; and

3) the complexity of presentations of adolescent emotional distress

Each of the three themes will be presented in turn and supported by illustrative quotations taken from the transcripts (see boxes 1-6). GP participants are identified by identifier number, gender, age range and whether salaried or a partner (as presented in Table 1.)

1. **i. Anxiety related to professional performance:** operating *In the consultation*

A coherent narrative emerged, gathered from almost all of the participants, of practitioners being anxious in the consultation because of an uncertainty about what to do and of what was expected of them, as primary care clinicians.

This resulted in a sense of professional impotence It was acknowledged that feeling uncertain about how best to proceed, and unsure of practice, led to a sense of disempowerment through not knowing what to do. This was in contrast to accounts of working with older patients where the options for GPs appear more clearly defined. The data generated by the open code analysis suggested that not being able to formulate the initial presentation by a young person into a definable 'disorder' created a sense of operating in uncharted territory.

Anxiety was amplified by the lack of exposure to adolescent mental health in undergraduate medical education which was the unanimous experience of all participants. Where the topic had been included in the curriculum, it was often restricted to severe mental disorder for example being assigned to medical teams looking after adolescents hospitalized with anorexia nervosa.

(See box 1).

1. **ii Anxiety related to professional performance:** operating *at an external level*

A lack of benchmarks in practice meant assessing one's performance in relation to peers was problematic since no 'gold standard' existed. The only NICE guideline which was referenced (concerning the management of depression in under 18 year olds) was regarded as having "hampered GPs" from becoming involved in the management of adolescent depression since the Guideline did not advocate the use

of anti-depressants and, with access to psychological therapies piecemeal, appeared to support a position that there was little to be offered in primary care.

Constraints in practice led to frustration and an anxiety about management. For example, varying arrangements within practices governing access to appointments and the ease, or not, of maintaining continuity of care were seen to contribute to professional anxiety by impeding attentive 'watchful waiting' and some GPs described attempts to circumvent inflexible appointment systems in order to be more available to patients.

A lack of professional supervision was identified by a small number of more experienced GPs involved with Postgraduate Training and provision of mental health services at a regional level, and contrasted to systems for other professionals working with emotionally distressed patients. Leaving GPs to rely on their own personal resources, on informal collegiate support or ad hoc relationships with colleagues in secondary care resulted in a fragile structure which could amplify rather than ameliorate anxiety.

(See box 2).

1. **iii Anxiety related to professional performance:** *across disciplinary boundaries*

GPs across the board expressed frustration with access to secondary care services, reporting long delays and frequent rejection of referrals, and a lack of clarity about how the services were structured and governed. GP experiences and degrees of frustration varied with an emerging picture of problematic access to services being associated with higher levels of professional anxiety. Where GPs described more constructive cross-disciplinary relationships, with CAMHS practitioners offering clinical updates meetings, and were consultants were accessible by telephone, less anxiety was voiced.

Unfamiliarity with the roles and responsibilities of CAMHS practitioners, coupled with an obligation to refer in the absence of other options, left some GPs feeling uncertain about the clinical care pathway and unsure about practice.

(See box 3.)

2. Anxiety related to interacting with young people

The open codes showed a dominant finding of GPs expressing anxiety associated with difficulties experienced when communicating with young people in general. Neither the age nor the gender of the GP appeared to facilitate communication, with younger and female GPs similarly as uneasy as older male and female GPs. Female patients were generally considered to be easier to talk with whilst young men were seen to be more challenging because of their perceived reluctance to seek help and their tendency to present late.

Communication difficulties included establishing a rapport, finding the right words and tone to use and dealing with silence. An inability to read the non-verbal signs, and to translate an often terse description from the young person into a coherent picture of their internal emotional state, left many GPs either relying on the accompanying parent or closing down the consultation. Being able to find common ground was identified as being key to beginning the process of establishing rapport.

Young people were seen as a highly heterogeneous group who showed variability from one presentation to the next (intra-variabillty), and also across lines of age and gender (inter-variability). Knowing what was 'normal' for an individual, particularly if it was presented as a principal reason for consulting with the GP, was perceived as problematic and anxiety provoking, both for the young person and for the GP.

(See box 4)

3. Anxiety associated with the complexity of presentations of adolescent emotional distress

GPs' accounts of their experiences consulting with young people experiencing distress described a terrain beset with pitfalls, associated with the unspoken or with complex narratives embedded in social contexts; and presented in an undifferentiated form. GPs spoke of a sense of unpredictability and volatility to presentations which left them uncertain about how the patient narrative might unfold and how much input to offer at the initial consultation. In particular this generated

anxiety associated with the rare but grave consequences which might arise when a young person seriously attempted or completed suicide; a clinical experience to which many GPs referred and which could lead to enduring professional anxiety. (See box 5).

Although it was accepted that uncertainty as a feature of general practice was not restricted to the clinical area of youth mental health, the first stage analysis showed a distinct narrative emerging in which adolescent mental health was seen as more notably anxiety provoking because of its more nebulous presentation and multiple confounding factors, which largely pertained to the social environment. The account given in the consulting room was described as the 'iceberg' indicating that often much is left hidden, or unsaid, but which nevertheless has to be raised at some point if the young person's distress is to be addressed.

Not only is there a dominant narrative of anxiety surrounding how GPs make sense of adolescent emotional distress, but similar responses are associated with management options. Few GPs expressed any degree of confidence about how they would tackle individual presentations. A small number of those with additional roles in mental health or working with patients with substance abuse problems spoke of a more systematic approach to organizing and offering care. However even established GPs with personal experience of working in 'a teen drop-in clinic' or with drug dependent patients described uncertainty about their practice. A paucity of treatment options was a consistent finding along with a lack of clarity about what GPs might reasonably be expected to do, if supported by adequate professional development.

Discussion

Summary

Anxiety about practice, coupled with a perceived reduced range of options and lack of clarity of expectations, associated with diverse presentations of adolescent emotional distress in primary care, emerged from all GP participant accounts in the first stage of analysis.Unease when communicating with young people and difficulties interpreting their accounts of distress inhibited GPs. This was

compounded by the complexity of presentations which ranged from familial discord to school refusal to offending behaviour, usually in the absence of any clear diagnosis. The heterogeneity of adolescent behaviour taxed GPs as did the unpredictability of the unfolding clinical presentation which might settle spontaneously or might develop into a serious mental health disorder.

Whilst there was a spectrum of levels of anxiety experienced by GPs, there was a prevailing universality about the experience. How GPs responded and managed the perceived threat to professional competence and confidence was interrogated in the next stage of the analysis which would lead to the development of the axial codes , or pillars, of the emerging conceptual model (presented elsewhere).

Strengths and limitations

The management of adolescent mental health problems remains an under-investigated area of clinical practice. Previous research has largely been conducted by psychiatrists whose perspective is different to that of GPs responding to undifferentiated distress in the consulting room.Using grounded theory, augmented by situational analysis, permits a rich exploration of the territory and facilities theory building.

Theoretical sampling supports theory development whilst not purporting to provide universal generalizability. After 19 in-depth interviews, buttressed by situational analysis, no new themes emerged and theoretical saturation was reached. All of the respondents were white British and whilst they were recruited on the basis of their contribution to the study, it must be acknowledged that the absence of including the experiences of GPs raised and educated in different cultural contexts will lead to the silencing of other cultural perspectives.

The lead researcher and interviewer is a GP (JR). Interviewing peers has been described [29]as enriching the data collection because of the shared knowledge and familiarity with the clinical territory but it can lead to collusion between interviewer and respondent which needs attention and reflexivity. Co-contributors AC and JF

have academic expertise in social policy and sociology which strengthened the analysis.

Comparison with existing literature

Heath asserts that *a commitment to uncertainty is fundamental to general practice:* [30]*:* 651) and Schon has described this operative landscape as a 'swampy lowland' proposing a model which advocates reflective practice as the key to dealing with uncertainty.[31] A quest for certainty in areas of complex practice, especially when it concerns individual experiences can be counter- productive and scholars have cautioned against clinging to the 'shelter of diagnosis' [15] when what is required involves attention to alleviating suffering and working purposefully with patients to catalyse their own creative capacity.[14] Illife et al's earlier cited work demonstrated that when GPs were fixed on the concept of depression as disease they were uncomfortable talking to young people. [32] [33]

This study which contributes to building a theoretical model, suggests that anxiety and, perceived threats to professional competence, can be experienced at multiple levels, and are amplified with regard to the complexity of adolescent presentations. This can compromise GP's professional engagement with young people. Understanding more about why some GPs can creatively respond to the anxiety and lack of certainty about expectations defines the next stage of the analysis.

Implications for practice and research

Inadequate educational preparation, both at under and post-graduate level, is pivotal in failing to address the anxiety around clinical practice. Doctors need to be introduced to the developmental trajectory of adolescence and the conceptual framework which locates adolescence as the foundation of future health [34] both in undergraduate education and revisited in continuing professional development . This approach will help GPs to understand more about why addressing emotional distress in the second decade of life is important.

GPs need good quality educational exposure and preparation to deal with the multi-axial development of adolescence and the emergence of mental health disorders in

the 10 to 20 year olds. The current psychiatric classification systems do not facilitate clinical practice in this domain at primary care level. In addition, the links between general practice and CAMHS need to be strengthened both in terms of education and understanding more of how each discipline operates, but also at a pragmatic, operational level. If cross-disciplinary practice was facilitated more treatment options would be presented at a primary care or early intervention level.

More research is needed to demonstrate evidence of effective, feasible, primary care based brief behavioural interventions which would equip GPs to engage with young people with greater confidence and support the development of evidence based policy .

At a systemic level, this study shows that external factors are important in influencing practice and can moderate or exacerbate levels of anxiety. Systems which improve access to care for young people need to be introduced at practice level and supported by policy.

The study was given ethical approval by the Hull and East Riding LREC. REC Reference No. 08/H1304/97 and the University of Sunderland's Ethics Committee.

Approval was given by the Research and Governance leads for the three PCT areas where recruitment took place: Stockton-on-Tees; Redcar & Middlesbrough ; County Durham and Darlington.

The RCGP Scientific Foundation Board awarded £ 3,850 to cover Transcription costs. No other funding was provided for the study.

There are no competing interests for any of the authors.

The authors agree to BMJOpen having exclusive licence to this original research.

Table 1

Participant Number	Gender	Age	Salaried or Partner	Practice descriptor	Additional professional experience
01	F	50-59	S	Semi-rural Deprived	GP Postgraduate education
02	Male	50-59	S	Urban Deprived	Addiction medicine in primary care
03	Female	50-59	P	Urban Deprived; wealthy student population	Former Assoc. Specialist in CAMHS
04	Female	40-49	S	Semi-rural Deprived	Mental health Lead for a PCT
05	Female	20-29	S	Urban Deprived	
06	Male	40-49	P	Semi-rural Largely affluent	
07	Male	40-49	P	Semi-rural Mixed :	Child Protection Lead for a PCT
8	Female	30-39	S	Semi-rural Mixed :	
9	Male	50-59	P	Semi-rural Mixed :	GP lead for 'teen drop-in' clinic
10	Male	40-49	P	Urban Deprived	Mental Health and Child Protection Lead for a PCT. Substance misuse

11	Female	20-29	S	Urban Deprived	
12	Male	30-39	S	Semi-rural Mixed: largely affluent	
13	Female	30-39	S	Urban Deprived	
14	Male	40-49	P	Urban Deprived	
15	Male	40-49	P	Semi-rural Mixed :	
16	Female	20-29	S	Urban Deprived	
17	Male	30-39	S	Urban Deprived	
18	Female	40-49	P	Semi-rural Affluent	
19	Female	50-59	P	Semi-rural Mixed :	Child health lead

Box 1 . Anxiety related to professional performance: In the consultation

I'm quite anxious about mental health problems in young people cos I don't have a huge experience.....and I don't want to waste their (CAMHS practitioners') time (09;M;50-59;P)

I've always thought young people are challenging and still do and I have more questions than answers' (06;M; 40-49;P)

I think they are a difficult group...partly because of the way they present...and there should be lots of resources for them and there aren't so not knowing what to do is a bit of a theme really...the main anxiety is what to do.... (07;M; 40-49;P)

I find the adults will accept me at face value, generally. And they come with something usually fairly clear and they want that sorting out, it might not be straight forward, it might not even be simple they might have even brought things off the internet but it is a fairly clear baggage package... what I find with younger people with psychological or emotional disorders is it's not a clearly packed problem, it's in the extreme realms of the undefined. (06;M;40-49;P)

Box 2. Anxiety related to professional performance: at an external level

'...because it doesn't fit within any ticky box guidelines until time has passed I rarely know whether I've done the right thing, it's all in retrospect. (06;M;40- 49;P)

I'll bring people back in 1 week, I don't think this annoys my partners but it can become a bugbear....I'll squeeze them in when there are no appointments, which is probably making a rod for my own back and I wouldn't encourage trainees to do it, but I like the idea of seeing something through to its natural conclusion...its perhaps my own insecurity (14;M; 40-49,P)

What we don't have, in general practice is supervision...no counsellors are allowed to work without it but GPs are just sent out there, and I really do feel there is a huge need for it even if it is just one phone call-it's that ability to share the responsibility, not to dump it, but to genuinely share it. (04;F; 40-49;S)

Box 3. Anxiety related to professional performance: across disciplinary boundaries

I know we don't meet all the people we refer to but we usually have something to hang it on because of our experience as junior doctors working in hospital but with CAMHS there is nothing. (08; F;30-39;S)

Some (mental health) creatures are on the verge of being mythical beasts, ...like psychotherapists,....educational psychologists (09,M;50-59;P)

CAMHs..it feels like it's a bit of a hotchpotch really, a patched together sort of service and I'm not sure who is control....people who counsel children-I don't know much about them, how much responsibility they take..... (07;M; 4049;M)

Box 4. Anxiety related to interacting with young people

Males with mental health issues worry me intensely, it really does seem that there is not an awful lot of trivia goes on there. By the time a male is presenting, because they don't have the tools to come to the GP very often, they don't understand that you can just come along when things are in their development, they usually come when something is really big ,black and bleak.(14;M;40-49;P)

I struggle a bit to work out how to word sort of mental health questions with to the sort of under 16 year olds particularly.... I suppose with adults I have my kind of, standard questions ..but using those sort of questions with young people often draws a blank face, and, so it's something I have to rephrase; I feel that I don't necessarily know their kind of lingo if you like...(17;M; 30-39;S)

Generally consulting with young people, I often find, if I'm being honest, probably more difficult than I would expect to find it. I think I probably have this unrealistic view of myself as really sort of approachable and you know still being quite young myself compared to other GPs, being able to communicate fairly easily and fairly well with young people, then always very quickly, it becomes apparent that actually no, you are a million miles away from where they are, and they don't really relate to you very well at all....(08; F; 30-39; S)

Box 5. Anxiety associated with the complexity of presentations of adolescent emotional distress

... you feel that there there are these big 'no go areas' in teenage consultations, around sex, drugs, alcohol... which loom over you like a black cloudand I'm thinking that they want to talk about it and I'm thinking that I want to talk about it but we can't talk about it... (11;F; 20-29; S)

They are missing school, in trouble with the police, youth offending team or not uncommonly the parent just comes by themselves...I never get a 14 year old acting out saying 'you know, I'm in trouble with my mam and dad' (10;M;40-49;P)

they are in absolute crisis one minute and then you see them a week later and they can hardly remember what it was all about (07;M; 40-49;P)

Its always a worry isn't it that you just completely get it wrong..I mean I'm conscious of this. I had someone in on Monday, parents, whose son had just hung himself at 21. I'd never seen him, he was a patient here. They had no idea anything was wrong. Nobody did....there is always that underlying things isn't there, that you might miss something catastrophic.. (01;F;50-59;S)

Contributorship:

JR was the lead researcher and conducted all the interviews. She performed the primary analyses and is first author. AC and JF were involved with the study design from conception, met regularly throughout the analytical phase and commented on each draft of the manuscript.

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Appendix 1 Early Topic Guide

1. I'd like to talk about your experiences of consulting with young people in general

- How do you find this age group?
- Is it very different to consulting with older patients?
- What sort of problems do you see? Do they consult often?

2. Can we talk more about consulting with young people who may have psychological/mental health problems

- How do you find this clinical area?
- What about seeing YP alone/ with 'another'
- Any areas particularly tricky to broach ?

3. How do you consider possible 'mental health problems' which presenting in young people ?

- Do any examples come to mind ?
- What approach did you take
- What worked well? What was difficult?
- Is it different with other age groups

4. What are your thoughts on 'depression' and 'anxiety in young people ?

- Do you see much of it?
- Does this differ from other age groups?
- What options are there in primary care?

5. Do you think GPs have a role/or not in promoting emotional well-being in young people? Explore

Research checklist

As this is a qualitative study it does not fall within the parameters of the recommended research checklists.

A statement to this effect is included in the covering letter.

".. I think this is maybe our Achilles Heel...." Exploring GPs' responses to young people presenting with emotional distress in general practice. A qualitative study.

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".. I think this is maybe our Achilles Heel...." Exploring GPs' responses to young people presenting with emotional distress in general practice. A qualitative study.

Article summary

Article Focus:

1. an exploratory study
2. to examine GPs' views and experiences of consulting with young people experiencing emotional distress
3. to better understand GPs perspectives

Key Messages

1. ~~GPs collectively describe a~~Anxiety about practice experienced when consulting with young people ~~and uncertainty~~ is the dominant finding in a first stage analysis of a qualitative study. ~~about their clinical practice when consulting with young people in distress,~~This is independent~~ly~~ of age and gender of GP
2. Anxiety relates to professional performance; interacting with young people and the complex nature of presentations of emotional distress in primary care
3. Unless anxiety and related uncertain~~y~~ties about practice are addressed GPs will continue to miss opportunities to address early emotional difficulties and young people's mental health needs in primary care will continue to be poorly met

Strengths and Limitations

1. Qualitative research in under -examined areas offers new insights and explores why behaviours might arise
2. The data presented contributes to ~~to~~ theory building ~~and offers theoretical generalizability~~
3. Theoretical sampling led to only white British born GPs participating so other cultural perspectives were not included

".. I think this is maybe our Achilles Heel...." Exploring GPs' responses to young people presenting with emotional distress in general practice. A qualitative study.

Main text

Introduction

Emotional distress in young people is common. It may be the affective response to the challenges of everyday life or may indicate a mental health disorder compatible with a psychiatric diagnosis~~an associated mental heath problem~~. The most recent and widely cited household survey reports ~~, with~~ at least 10% of 10-15 year olds ~~affected~~ [1] and 17 % of 16-19 year olds [2] ~~(based on household surveys~~ to) to have symptoms consistent with a mental health disorder as defined by the ICD-10. Behavioural manifestations of emotional distress might include ~~Proxy markers of distress, such as reported incidences of~~ self-harm which, at a conservative estimate, appears to affect around 10% of adolescents, as reported in six studies cited by Hawton et al in a recently published review ~~derived from community based studies, show 10% of adolescents report having self-harmed~~. [3]

Data from populations of young people who consult their GP reveal higher rates of psychological distress, of the order of 20-30%. [4 5] GPs identify serious mental illness but often fail to detect less severe manifestations [6] and appear reluctant to discuss emotional issues[7]; unless offered cues by the young person in the consultation [8] or if other factors are present such as a previous history of a suicide attempt or a pattern of frequent consulting [9]. Young people's presentations in primary care are often complex and present with behavioural, psychosocial, academic and familial problems which can be problematic to untangle in contrast to adult mental health manifestations which, although variable, may be less intense in their presentation . ~~They~~ Adolescent emotional distress may ~~suggest~~ indicate underlying co-morbid

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mental health problems. and it It has been reported suggested that often the 'most important features in terms of assessment may be concealed or hidden'.[10]

A key concern is the difficulty of distinguishing between 'moodiness' or a persisting emotional disorder and GPs have expressed a worry at 'over-medicalising young people's lives'.[11] Illiffe & colleagues found that GPs were uncomfortable about making a diagnosis of depression in young people (the most common, but often coexisting, mental health problem in adolescence).

This sits in contrast to On the other hand GPs' are increasingly involved ment of in managing common mental health problems in older patients[12] [13] and also to a broadening of the frames of reference by which emotional distress in adults is regarded. Although a biomedical perspective dominates, supported by an array of NICE clinical guidelines, alternative frameworks for considering adult mental health problems have been offered . Dowrick[13][14] and Reeve[14][15] have offered alternative frameworks and refer to the insights derived from the wisdom traditions in informing their work which moves away from a positivist understanding of emotional distress to an approach which incorporates ideas of personal agency and encourages hope.[15] Historically, research has found GPs have been found to be largely dismissive of their role in addressing social issues in adult mental ill-health[16]. Contemporary studies reveal a shift although this position is shifting with greater awareness of the lay perspective, which typically favours the a social model causes of adult mental ill-health (notably depression) as being social in origin[17], and a matched response by GPs mirroring popular social constructions of distress .

Despite the challenge of responding to emotional distress in adolescence and the patchy, often inadequate provision of secondary care services[18] [19] a series of policy directives have emphasised the role of GPs and other front-line services, in the promotion of psychological well-being and the early indication of difficulties.[20] [21] [22] Practitioners are expected to have 'sufficient knowledge, training and support 'in this area including competence in 'active listening' and conversational technique'[23].

There is a growing body of evidence examining young people's experiences of talking to GPs about emotional problems. They reveal a mixed picture including a reluctance to disclose[24], a fear of being judged or offered medication[25]. Much less

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is known about GP perspectives. This paper presents a qualitative, exploratory study which examines GPs' views and experiences of consulting with young people presenting with emotional distress.

Method

Study Design

The study took place in the North East of England in 18 general practices based in urban, rural and semi-rural communities serving predominantly socio-economically disadvantaged patients. The qualitative study comprised of in depth individual interviews with GPs recruited using theoretical sampling. As early theoretical ideas emerged successive GPs were recruited on the basis of their capacity to contribute to the development or abandonment of initial theoretical constructs.

Data were collected between January 2010 to May 2011

Participants

GPs with less than four years clinical experience were excluded. The initial recruits were selected on the basis of their relevant experience ~~ a~~nd their ability to generate early data which would scope the terrain of the area under enquiry~~.~~; for example having a role as mental health lead or previous experience working in Child & Adolescent Mental Health services (CAMHS)

GPs were approached by telephone and email contact and sent information sheets. A follow-up contact established their verbal consent to meet at a location of their choice. Two GPs approached declined to participate. One cited forthcoming extended annual leave and another a view that as the senior partner he saw relatively few younger aged patients and suggested recruitment of a younger GP in the same practice.

Ethical approval by the Local Research Ethics Committee, the seven Primary Care Trust organizations of the region and the University of Sunderland was granted before data collection began.

Data collection and analysis

The audio-taped semi-structured interviews were transcribed verbatim with consent. An initial topic guide was used with the first tranche of participants based on the extant literature and developed through discussion. The topic guide was then revised on the basis of ideas arising from the early interviews, and the iterative analysis which began as soon as the first interview was undertaken. The interview guides explored doctors' experiences of consulting with young people in general and those presenting with psychological or mental health problems, GPs' understanding of depression and anxiety in adolescence, of how emotional distress presents in the surgery and the role of the GP in promoting emotional well-being in young people (See appendix 1). The guide was refined to include questions about how structural changes impacted on, and consultation style shaped, practice.

The interviews lasted between 50 to 75 minutes. Field notes and theoretical memos were kept throughout the period of data collection and analysis.

The transcripts were coded and analysed using the grounded theory method described by Strauss and Glaser [26] and revised by Charmaz .[27] The constant comparative method of analysis is core to the process and informs the theoretical sampling of recruits. Early ideas were tested with subsequent participants and found to be either substantiated or rejected through the iterative process of constant comparison supported by theoretical sampling .Situational maps, both 'messy' and 'ordered', were constructed during this phase of analysis.[28]

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The data presented here w~~as~~ere ~~produced~~ generated ~~-~~after the first level of analysis was completed, during which only the open codes were iteratively developed by JR and subject~~ed~~ to further examination by AC (primary care academic) and JF(sociologist). Further analysis of the axial and selective codes will be presented in two subsequent companion papers.

Results

Nineteen GPs participated, 10 women. (Table1). The early iterative analysis of the data found the open codes to support a dominant narrative of anxiety ~~and uncertainty about practice~~ under-pinning the majority of the research interviews. This

pervasive and disabling emotional response to encounters with emotionally distressed young people appeared to coalesce around three domains.

These can be viewed as anxiety ~~and uncertainty~~ experienced by GPs in response to:

1) professional performance; in the consultation, at an external level, across disciplinary boundaries;

2) interacting with young people; and

3) the complexity of presentations of adolescent emotional distress

Each of the three themes will be presented in turn and supported by illustrative quotations taken from the transcripts (see boxes 1-6). GP participants are identified by identifier number, gender, age range and whether salaried or a partner (as presented in Table 1.)

1. i. **Anxiety related to professional performance:** operating *In the consultation*

A coherent narrative emerged, gathered from almost all of the participants ,of practitioners being anxious in the consultation because of an uncertainty about what to do and of what was expected of them.as primary care clinicians

~~A prevailing finding was the~~ This resulted in a sense of professional impotence ~~which was associated with seeing or suspecting emotional distress in this age group.~~ It was acknowledged that feeling uncertain about how best to proceed, and unsure of practice, led to a sense of disempowerment ~~-~~through not knowing what to do~~;~~. This was ~~-~~in contrast to accounts of working with older patients where the options for GPs appear more clearly defined. The data generated ~~collected~~ by the open code analysis suggested that not being able to formulate the initial presentation by a young person into a definable 'disorder' created a sense of operating in uncharted territory.

~~This~~ Anxiety was amplified by the lack of exposure to adolescent mental health in undergraduate medical education which was the unanimous~~ly~~ experience ~~shared by~~ of all participants. Where the topic had been included in the curriculum, it was often

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restricted to severe mental disorder for example being assigned to medical teams looking after ~~such as~~ adolescents hospitalized with anorexia nervosa.

(See box 1).

1. ii **Anxiety related to professional performance:** operating *at an external level*

~~The~~ A lack of benchmarks in practice meant assessing one's performance in relation to peers was problematic since no 'gold standard' existed. The only NICE guideline which was referenced (concerning the management of depression in under 18 year olds) was regarded as having "hampered GPs" from becoming involved in the management of adolescent depression since the Guideline did not advocate the use of anti-depressants and, with access to psychological therapies piecemeal, appeared to ~~and~~ suppor~~ting~~ a position ~~view~~ that there was little to be offered in primary care.

Constraints in practice led to frustration and an anxiety about management. For example, ~~V~~varying arrangements within practices governing access to appointments and the ease, or not, of maintaining continuity of care were seen to contribute to professional anxiety by impeding attentive 'watchful waiting' and some GPs described attempts to circumvent inflexible appointment systems in order to be more available to patients.

A lack of professional supervision was identified by a small number of more experienced GPs involved with Postgraduate Training and provision of mental health services at a regional level, and contrasted to systems for other professionals working with emotionally distressed patients. Leaving GPs to rely on their own personal resources, on informal collegiate support or ad hoc relationships with colleagues in secondary care resulted in a fragile structure which could amplify rather than ameliorate anxiety.

(See box 2).

1. iii **Anxiety related to professional performance:** *across disciplinary boundaries*

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GPs across the board expressed frustration with access to secondary care services, reporting long delays and frequent rejection of referrals, and a lack of clarity about how the services were structured and governed. GP experiences and degrees of frustration varied with an emerging picture of problematic access to services being associated with higher levels of professional anxiety. Where GPs described ~~M~~more constructive cross-disciplinary relationships ~~were described~~ with CAMHS ~~workers~~ practitioners offering clinical updates meetings, and were consultants were accessible by telephone, less anxiety was voiced.

Unfamiliarity with the roles and responsibilities of CAMHS practitioners, coupled with an obligation to refer in the absence of other options, left some GPs feeling uncertain about the clinical care pathway and unsure about practice.

(See box 3.)

2. Anxiety related to interacting with young people

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The open codes showed a dominant finding of GPs expressing ~~The early finding of~~ anxiety ~~and uncertainty in this area was under-pinned by~~ associated with ~~the~~ difficulties ~~GPs talked about~~ experienc~~ed~~ing when communicating with young people in general. Neither the age nor the gender of the GP appeared to facilitate communication, with younger and female GPs similarly as uneasy as older male and female GPs . Female patients were generally considered to be easier to talk with whilst young men were seen to be more challenging because of their perceived reluctance to seek help and their tendency to present late.

Communication difficulties included establishing a rapport, finding the right words and tone to use and dealing with silence. An inability to read the non-verbal signs, and to translate an often terse description from the young person into a coherent picture of their internal emotional state, left many GPs either relying on the accompanying parent or closing down the consultation. Being able to find common ground was identified as being key to beginning the process of establishing rapport.

Young people were seen as a highly heterogeneous group who showed variability from one presentation to the next (intra-variabillty) , and also across lines of age and gender (inter-variability). Knowing what was 'normal' for an individual, particularly if it

was presented as a principal reason for consulting with the GP, was perceived as problematic and anxiety provoking, both for the young person and for the GP.

(See box 4)

3. Anxiety associated with the complexity of presentations of adolescent emotional distress

GPs' accounts of their experiences consulting with young people experiencing distress described a terrain beset with pitfalls, associated with the unspoken or with complex narratives embedded in social contexts; and presented in an undifferentiated form. GPs spoke of ~~There was~~ a sense of unpredictability and volatility to presentations which left ~~GPs~~ them uncertain about how the patient narrative might unfold and how much input to offer at the initial consultation. ~~This was in contrast~~ In particular this generated anxiety associated with ~~to~~ the rare but grave consequences which might arise when a young person seriously attempted or completed suicide; a clinical experience to which many GPs referred and which could lead to enduring professional anxiety. (See box 5)

Although it was accepted that uncertainty as a feature of general practice was not restricted to the clinical area of youth mental health, the ~~early~~ first stage analysis showed a distinct narrative emerging in which adolescent mental health was seen as more notably anxiety provoking because of its more nebulous presentation and multiple confounding factors, which largely pertain~~inged~~ to the social environment. The account given in the consulting room was described as the 'iceberg' indicating that often much is left hidden, or unsaid, but which nevertheless has to be raised at some point if the young person's distress is to be addressed.

Not only is there a dominant narrative of anxiety ~~and uncertainty~~ surrounding how GPs make sense of adolescent emotional distress, but similar responses ~~surround~~ are associated with management options. Few GPs expressed any degree of confidence about how they would tackle individual presentations. A small number of those with additional roles in mental health or working with patients with substance abuse problems spoke of a more systematic approach to organizing and offering care. However ~~but~~ even established GPs with personal experience of working in 'a

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teen drop-in clinic' or with drug dependent patients ~~were~~ described uncertainty about ~~uncertain of~~ their practice. A paucity of treatment options was a consistent ~~re~~ finding along with a lack of clarity about what GPs might reasonably be expected to do, if supported by adequate professional development.

Discussion

Summary

Anxiety ~~and uncertainty~~ about practice, coupled with a perceived reduced range of options and lack of clarity of expectations, associated with diverse presentations of adolescent emotional distress in primary care, emerged from all GP participant accounts in the first stage of analysis. ~~and from the early iterative analysis of the data. Anxiety was associated with the clinical consultation, with what was expected of the GP, and how they might best respond in the absence of few clinical guidelines and limited options to involve other health and social care professionals~~. Unease when communicating with young people and ~~of~~difficulties interpreting their accounts of distress inhibited GPs. ~~and~~ This was compounded by the complexity of presentations which ranged from familial discord to school refusal to offending behaviour~~.~~, usually in the absence of any clear diagnosis. The heterogeneity of adolescent behaviour taxed GPs as did the unpredictability of the unfolding clinical presentation which might ~~could~~ settle spontaneously or might develop into a serious mental health disorder.

Whilst there was a spectrum of levels of anxiety experienced by GPs, there was a prevailing universality about the experience. How GPs responded and managed the perceived threat to professional competence and confidence was interrogated in the next stage of the analysis which would lead to the development of the axial codes , or pillars, of the emerging conceptual model (presented elsewhere).

Strengths and limitations

The management of adolescent mental health problems remains an under-investigated area of clinical practice. Previous research ~~studies~~ has~~ve~~ largely~~often~~ been conducted by psychiatrists whose perspective is different to that of GPs

responding to undifferentiated distress in the consulting room ~~and whilst plurality of perspectives is important, unless more is known and understood about how GPs perceive the area many assumptions will go unchallenged.~~ Using grounded theory, augmented by situational analysis, permits a rich exploration of the territory and facilities theory building.

Theoretical sampling supports theory development whilst not purporting to provide universal generalizability. After 19 in-depth interviews, buttressed by situational analysis, no new themes emerged and theoretical saturation was reached. All of the respondents were white British and whilst they were recruited on the basis of their contribution to the study, it must be acknowledged that the absence of including the experiences of GPs raised and educated in different cultural contexts will lead to the silencing of other cultural perspectives.

The lead researcher and interviewer is a GP (JR). Interviewing peers has been described [29]as enriching the data collection because of the shared knowledge and familiarity with the clinical territory but it can lead to collusion between interviewer and respondent which needs attention and reflexivity. Co-contributors AC and JF have academic expertise in social policy and sociology which strengthened the analysis.

Comparison with existing literature

Heath asserts that *a commitment to uncertainty is fundamental to general practice:* [30]*:* 651) and Schon has described this operative landscape as a 'swampy lowland' proposing a model which advocates reflective practice as the key to dealing with uncertainty.[31] A quest for certainty in areas of complex practice, especially when it concerns individual experiences can be counter- productive and scholars have cautioned against clinging to the 'shelter of diagnosis' [15]~~32~~ when what is required involves attention to alleviating suffering and working purposefully with patients to catalyse their own creative capacity.[14]~~15~~ Illife et al's earlier cited work demonstrated that when GPs were fixed on the concept of depression as disease they were uncomfortable talking to young people. [32]~~33~~ [33]~~34~~

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This study which contributes to building a theoretical model, suggests that ~~it is the~~ anxiety and,perceived ~~-~~threats to professional competence, can be experienced at multiple levels, and are amplified with regard to the complexity of adolescent presentations.This ~~and perceived paucity of management options which~~ can compromis~~ese~~ GP's~~s'~~ professional engagement ~~and inhibits them from taking a more active role.~~with young people. Understanding more about why some GPs can creatively respond to the anxiety and lack of certainty about expectations defines the next stage of the analysis.

Implications for practice and research

Inadequate educational preparation, both at under and post-graduate level, is pivotal in failing to address ~~sustaining~~ the anxiety around clinical practice. Doctors need to be introduced to the developmental trajectory of adolescence and the conceptual framework which locates adolescence as the foundation of future health [34~~35~~] both in undergraduate education and revisited in continuing professional development . This approach will help GPs to understand more about why addressing emotional distress in the second decade of life is important.

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GPs need good quality educational exposure and preparation to deal with the multi-axial development of adolescence and the emergence of mental health disorders in the10 to 20 year olds. The current psychiatric classification systems do not facilitate clinical practice in this domain at primary care level.

In addition, the links between general practice and CAMHS need to be strengthened both in terms of education and understanding more of how each discipline operates, but also at a pragmatic, operational level. If cross-disciplinary practice was facilitated more treatment options would be presented at a primary care or early intervention level .

More research is needed to demonstrate ~~E~~evidence of effective, feasible, primary care based brief behavioural interventions which would equip GPs to engage with young people with greater confidence and support the development of evidence based policy .

At a systemic level, this study shows that external factors are important in influencing practice and can moderate or exacerbate levels of anxiety. Systems which improve access to care for young people need to be introduced at practice level and supported by policy.

~~The needs of young people are ill- served by the current provision [18] [19] and whilst rhetoric has called for GPs to be more involved, unless we address the disabling anxiety and uncertainty in this area practice will remain static with GPs reluctant to become involved in youth mental health.~~

How this fits in

GPs are known to have difficulty recognizing and responding to adolescent emotional distress. Reluctance to medicalize distress has been reported.

This study shows that anxiety ~~and uncertainty~~ about practice in this complex clinical area ~~are~~is universal and independent of age, gender, and level of experience of GP.

If GPs are to play a more active role in the early identification and intervention of distress we need to know more about ~~the factors which ameliorate or exacerbate professional anxiety about practice.~~ what promotes or inhibits professional anxiety and facilities greater GP engagement with young people

Critically, adolescent mental health needs to feature in undergraduate and postgraduate curricula.

Table 1

Participant Number	Gender	Age	Salaried or Partner	Practice descriptor	Additional professional experience
01	F	50-59	S	Semi-rural Deprived	GP Postgraduate education
02	Male	50-59	S	Urban Deprived	Addiction medicine in primary care
03	Female	50-59	P	Urban Deprived; wealthy student population	Former Assoc. Specialist in CAMHS
04	Female	40-49	S	Semi-rural Deprived	Mental health Lead for a PCT
05	Female	20-29	S	Urban Deprived	
06	Male	40-49	P	Semi-rural Largely affluent	
07	Male	40-49	P	Semi-rural Mixed :	Child Protection Lead for a

					PCT
8	Female	30-39	S	Semi-rural Mixed :	
9	Male	50-59	P	Semi-rural Mixed :	GP lead for 'teen drop-in' clinic
10	Male	40-49	P	Urban Deprived	Mental Health and Child Protection Lead for a PCT. Substance misuse
11	Female	20-29	S	Urban Deprived	
12	Male	30-39	S	Semi-rural Mixed: largely affluent	
13	Female	30-39	S	Urban Deprived	
14	Male	40-49	P	Urban Deprived	
15	Male	40-49	P	Semi-rural Mixed :	
16	Female	20-29	S	Urban Deprived	
17	Male	30-39	S	Urban Deprived	
18	Female	40-49	P	Semi-rural Affluent	
19	Female	50-59	P	Semi-rural Mixed :	Child health lead

Anxiety paper Boxes i

Box 1. Anxiety related to professional performance: In the consultation

I've always thought young people are challenging and still do and I have more questions than answers' (06;M; 40-49;P)

so not knowing what to do is a bit of a theme really (07;M; 40-49;P)

I find the adults will accept me at face value, generally. And they come with something usually fairly clear and they want that sorting out, it might not be straight forward, it might not even be simple they might have even brought things off the internet but it is a fairly clear baggage package... what I find with younger people with psychological or emotional disorders is it's not a clearly packed problem, it's in the extreme realms of the undefined. (06;M;40-49;P)

I know we don't meet all the people we refer to but we usually have something to hang it on because of our experience as junior doctors working in hospital but with CAMHS there is nothing. (08; F;30-39;S)

Box 2 Anxiety related to professional performance: at a structural level

NICE guidelines a few years ago looked at depression in young people and kind of hampered our ability to do anything with them really (07;M; 40-49;P)

'...because it doesn't fit within any ticky box guidelines until time has passed I rarely know whether I've done the right thing, it's all in retrospect. (06;M;40- 49;P)

I'll bring people back in 1 week, I don't think this annoys my partners but it can become a bugbear....I'll squeeze them in when there are no appointments, which is probably making a rod for my own back and I wouldn't encourage trainees to do it, but I like the idea of seeing something through to its natural conclusion...its perhaps my own insecurity (14;M; 40-49,P)

What we don't have, in general practice is supervision...no counsellors are allowed to work without it but GPs are just sent out there, andI really do feel there is a huge need for it even if it is just one phone call-it's that ability to share the responsibility, not to dump it, but to genuinely share it.(04;F; 40-49;S)

Comment [J1]: i need to change structural to extenal

Anxiety Boxes ii

Box 3. Anxiety related to professional performance: across disciplinary boundaries

Some (mental health) creatures are on the verge of being mythical beasts, ...like psychotherapists,....educational psychologists (09,M;50-59;P)

CAMHs..it feels like it's a bit of a hotchpotch really, a patched together sort of service and I'm not sure who is control....people who counsel children-I don't know much about them, how much responsibility they take.. (07;M; 4049;M)

Box 4. Anxiety related to interacting with young people

Generally consulting with young people, I often find, if I'm being honest, probably more difficult than I would expect to find it. I think I probably have this unrealistic view of myself as really sort of approachable and you know still being quite young myself compared to other GPs, being able to communicate fairly easily and fairly well with young people, then always very quickly, it becomes apparent that actually no, you are a million miles away from where they are, and they don't really relate to you very well at all....(08; F; 30-39; S)

Males with mental health issues worry me intensely, it really does seem that there is not an awful lot of trivia goes on there. By the time a male is presenting, because they don't have the tools to come to the GP very often, they don't understand that you can just come along when things are in their development, they usually come when something is really big ,black and bleak.(14;M;40-49;P)

I struggle a bit to work out how to word sort of mental health questions with to the sort of under 16 year olds particularly.... I suppose with adults I have my kind of, standard questions ..but using those sort of questions with young people often draws a blank face, and, so it's something I have to rephrase; I feel that I don't necessarily know their kind of lingo if you like...(17;M; 30-39;S)

So he went off to do a urine sample and I was pleased to speak to his parents without him, seemed easier to talk about some of the mental issues without him there... (017;M; 30-39;S)

With children and teenagers it tends to be you controlling the pace of the consultation.... and you finish the consultation when you want to (07;M; 40-49;P)

Anxiety Box iii

Box 4. Anxiety related to interacting with young people

there's no such thing as a typical teenage presentation (13;F; 30-29;S)

...and her mum said, as mum's do, oh she has dreadful mood swings on her periods, it's like living with a monster ..and then they say 'but that's normal isn't it, she is 14?'... so it's hard to know what to do (11;F; 20-29;F)

Box 5. Anxiety associated with the complexity of presentations of adolescent emotional distress

... you feel that there are these big 'no go areas' in teenage consultations which loom over you like a black cloud (11;F; 20-29; S)

They are missing school, in trouble with the police, youth offending team or not uncommonly the parent just comes by themselves...I never get a 14 year old acting out saying 'you know, I'm in trouble with my mam and dad' (10;M;40-49;P)

they are in absolute crisis one minute and then you see them a week later and they can hardly remember what it was all about (07;M; 40-49;P)

Its always a worry isn't it that you just completely get it wrong..I mean I'm conscious of this. I had someone in on Monday, parents, whose son had just hung himself at 21. I'd never seen him, he was a patient here. They had no idea anything was wrong. Nobody did....there is always that underlying things isn't there, that you might miss something catastrophic.. (01;F;50-59;S)

Anxiety Box iii

Box 5. Anxiety related to interacting with young people

there's no such thing as a typical teenage presentation (13;F; 30-29;S)

...and her mum said, as mum's do, oh she has dreadful mood swings on her periods, it's like living with a monster ..and then they say 'but that's normal isn't it, she is 14?'... so it's hard to know what to do (11;F; 20-29;F)

Box 6. Anxiety associated with the complexity of presentations of adolescent emotional distress

... you feel that there are these big 'no go areas' in teenage consultations which loom over you like a black cloud (11;F; 20-29; S)

They are missing school, in trouble with the police, youth offending team or not uncommonly the parent just comes by themselves...I never get a 14 year old acting out saying 'you know, I'm in trouble with my mam and dad' (10;M;40-49;P)

they are in absolute crisis one minute and then you see them a week later and they can hardly remember what it was all about (07;M; 40-49;P)

Its always a worry isn't it that you just completely get it wrong..I mean I'm conscious of this. I had someone in on Monday, parents, whose son had just hung himself at 21. I'd never seen him, he was a patient here. They had no idea anything was wrong. Nobody did....there is always that underlying things isn't there, that you might miss something catastrophic.. (01;F;50-59;S)

*Uncertainty is very key to this group when you're looking - in terms of depression and suicide risk and things like that, you know, it's standard. Young people particularly young males are quite at risk of just going off and doing something. (*04; F; 40-49;S*)*

The main anxiety is what to do. (07;M; 40-49;P)

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